



Breakspear Hospital

CHILD Medical Questionnaire and Consent Form for BCG & Skin Test

Please complete all the white boxes and bring the completed form and your child's Developmental Book to the initial consultation.

Date of first appointment (dd/mm/yyyy)

Child's details:

Child's first name

Child's surname

Male

Female

Date of birth (dd/mm/yyyy)

Address

Post code

Parent's/Guardian's details:

First name

Surname

Contact number

Alternative

Child's GP name

GP address

GP contact number

Child's condition:

1. Has your child ever had a vaccination against Tuberculosis (BCG) or a recent skin test? Yes No
2. In the last 3 months, has your child received a high dose of steroid therapy or any other immunosuppressant medication? Yes No
3. Has your child been treated for leukaemia or malignant disease? Yes No
4. Is there any known HIV infection, including infants born to HIV positive mothers? Yes No
5. Has your child ever been treated for tuberculosis or is your child currently receiving TB treatment? Yes No
6. In the last 3 weeks, has your child had a severe viral infection? Yes No
7. In the last 3 months, has your child had any infection needing antibiotics? Yes No
8. In the last 3 months, has your child had any injection or blood transfusion? Yes No
9. Has your child ever had an adverse reaction to any immunisation? Yes No
10. Is your child suffering from a generalised skin infection or infected eczema? Yes No
11. Does your child have any known allergies to the vaccine components? Yes No
12. Has your child ever travelled outside the United Kingdom? Yes No
13. Has your child had any known contact with TB? Yes No
14. Does your child have any other medical conditions? Yes No

If yes, please explain.

15. If applicable: Date of last menstrual cycle (dd/mm/yy)

Vaccination will be postponed if your child has a temperature above 37.3 °C at consultation.

I hereby consent for my child (full name) _____ to receive a skin test and a BCG immunisation or referral to a chest clinic, whichever proves necessary.

I confirm that I have parental responsibility for the child.

Signature of parent/guardian _____

Date _____

HOSPITAL USE ONLY

BCG Vaccination

Date	<input type="text"/>	Temperature	<input type="text"/>
Medical conditions	<input type="text"/>	Injection site	<input type="text"/>
General Health on day of vaccination	<input type="text"/>	Batch number	<input type="text"/>
Vaccine	<input type="text"/>	Dose	<input type="text"/>
		Exp date	<input type="text"/>
		Make	<input type="text"/>
Doctor's signature	<input type="text"/>	Nurse's signature	<input type="text"/>

Mantoux Skin Test

Patient's name	<input type="text"/>	Temperature	<input type="text"/>
Batch number	<input type="text"/>	Date & time of skin test	<input type="text"/>
Manufacturer	<input type="text"/>	Exp date	<input type="text"/>
Injection site	<input type="text"/>	Dose & strength administered	<input type="text"/>
Date to be read	<input type="text"/>	Date and time test read	<input type="text"/>
Results in mm	<input type="text"/>		
Adverse reactions	<input type="text"/>		
Any blistering present	<input type="text"/>		
Any ulceration present	<input type="text"/>		
BCG required	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Referral required	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Doctor's signature	<input type="text"/>	Nurse's signature	<input type="text"/>
Any concerns	<input type="text"/>		
Notes	<input type="text"/>		